Claims Payment Policies & Other Information

Use This Document Along with Your Summary of Benefits And Coverage and Detailed Benefit Grid

IN-NETWORK VERSUS OUT-OF-NETWORK CARE

All Highmark plan options let you choose your providers. When you need medical care, you can choose between **in-network** and **out-of-network** providers. It's important to understand the difference because your choice affects how much you pay for services. For example, some plans do not cover care from out-of-network providers, except for emergencies and a few other situations.

IN-NETWORK CARE

Doctors and hospitals that participate with us are called "in-network" providers. In-network providers include primary care doctors, specialists, hospitals, and a variety of treatment facilities. By keeping care in network, medically necessary and appropriate care will be covered at the lowest cost to you.

You can use this information to find your plan's in-network doctors and hospitals.

- **Call My Care Navigator at 1-888-BLUE-428.**
- Visit **highmarkblueshield.com** and click **Find Doctors and Rx.**

OUT-OF-NETWORK CARE

Doctors and hospitals that do not participate with us are called "out-of-network" providers. Please refer to your plan details to understand what coverage you may or may not have with out-of-network providers. Refer to your Summary of Benefits for a plan's specific coverage.

MEDICAL NECESSITY, PRIOR AUTHORIZATIONS AND REVIEWS

MEDICALLY NECESSARY AND APPROPRIATE

Our Clinical Services team helps you get proper care. They work with your doctor, using specific guidelines to determine if care is medically necessary and appropriate.

Medically necessary and appropriate care helps ensure that you receive the right type of care, in the right place, and for the proper length of time. Medically necessary and appropriate care:

- Must be generally accepted as medical practice standards
- Must be clinically appropriate in type, frequency, extent, site, and duration
- Must be considered effective for your illness, injury, or disease
- Must not be for your or your provider's convenience
- Must not be more costly than another service that may give you similar results

No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate. If we denied coverage of a service or claim, you have the right to appeal the denial decision. More information about this process is included in the benefit booklet that you will receive after you enroll.

PRIOR AUTHORIZATION, OR PRESERVICE REVIEW

We must approve some services before you can get them. This is called prior authorization, or preservice review.

If you need a service that we must first approve, your in-network doctor will call us to get the authorization. An example of a service needing prior authorization is any kind of inpatient hospital care (except maternity care). If you don't get the prior authorization, you may have to pay up to the full amount of the charges.

The number to call for prior authorization is included on the ID card you will receive after you enroll. Please refer to the specific coverage information you will receive after you enroll.

PRIOR AUTHORIZATION, OR PRESERVICE REVIEW TIME FRAMES AND ENROLLEE RESPONSIBILITIES

Our Clinical Services team helps you get care:

- In the right setting
- At the appropriate cost
- With the right outcomes

Your plan pays for covered services, supplies, or medications that are medically necessary and appropriate. These might be to prevent, evaluate, diagnose, or treat an illness, injury, or disease, or its symptoms. They:

- Must be generally accepted as standards of medical practice
- Must be clinically appropriate in type, frequency, extent, site and duration
- Must be considered effective for your illness, injury, or disease
- Must not be for your or your provider's convenience
- Must not be more costly than another service that may give you similar results

An in-network provider will contact Highmark's Clinical Services team to authorize your care.

No Referrals Needed — All Highmark plans let you see a specialist without needing a referral from your primary care doctor.

What We Cover — Please refer to the Summary of Benefits and Coverage and detailed benefit grid.

This includes inpatient and outpatient non-emergency care. It is their right to decide if a service, supply, or medication is medically necessary and appropriate. They do this before your plan pays benefits. Your plan will not pay benefits if our team of doctors and nurses decides that the service, supply, or covered medication is not medically necessary and appropriate.

A decision on a request for prior authorization for medical services will typically be made within 72 hours of us receiving the request for urgent cases or 15 days for non-urgent cases.

OUT-OF-NETWORK SERVICES

It's different if you are admitted to an out-of-network facility. In this case, you must call Highmark's Clinical Services team to find out if the covered services are medically necessary and appropriate. This does not apply to emergencies.

Call Highmark's Clinical Services team for precertification at the Member Service number on the back of your ID card before you are admitted to an out-of-network facility, so that you understand your financial responsibility. You should:

- Call seven to 14 days before your planned admission
- Call within 48 hours after an emergency or maternity-related admission
- Call as soon as you can as the last option

WHAT HAPPENS IF YOU DON'T CALL?

If you do not call to authorize an out-of-network admission, Clinical Services will review your care after you receive services. Clinical Services will decide if the covered service you received was medically necessary and appropriate. If Clinical Services decides that it was not, you will be responsible for all hospital charges.

Out-of-network providers do not have to contact Clinical Services. If they do, they do not have to accept Clinical Services decision. As a result, you may receive services that are not considered medically necessary and appropriate under your plan. You could be responsible for their costs.

POST-SERVICE, OR RETROSPECTIVE REVIEW

If we denied payment for a service that you already had, your doctor may ask for a "retrospective review." For this review, we will take a detailed look at your records and information to determine if the services were medically necessary and appropriate.

CONTINUED STAY, OR CONCURRENT REVIEW

If you are admitted to the hospital and your doctor feels that you may need more days of care, a "concurrent review" may happen. A concurrent review is a detailed review while you are still in the hospital. We do this to determine if the additional in-hospital services are medically necessary and appropriate. Decisions on a request for concurrent review are typically made within 24 hours of receipt.

CASE MANAGEMENT

If you have specific health needs, we may offer a collaborative Care Management process that involves our team, you, your physician, and other providers, to explore potential treatment options. Care Management works to identify and coordinate alternative approaches that are medically appropriate, cost-effective, and support your overall well-being. This includes offering enhanced care coordination, disease management programs, and potentially other support services designed to help you manage your health effectively and make informed decisions about your care.

NON-COVERED SERVICES

Covered and non-covered services may vary by plan.
Please keep in mind that you could be responsible for the total amount of any services not covered by your plan. For more information about services your plan covers, please refer to the benefit materials available to you after you enroll in your Highmark health plan or to the Summary of Benefits and Coverage.

NON-COVERED SERVICES INCLUDE, BUT ARE NOT LIMITED TO:

- Personal hygiene and convenience items
- Services rendered prior to the member's effective date or after the termination date of coverage
- Custodial care, domiciliary care, and protective and supportive care, including educational service, rest cures, and convalescent care
- Services that are experimental/investigative in nature
- Services which are not medically necessary or appropriate
- Immunizations required for foreign travel or employment, except as otherwise set forth in the Preventive Schedule
- Treatment of sexual dysfunction that is not related to organic disease or injury
- Services for or related to surrogate pregnancy
- Routine or periodic physical examinations, except as set forth in the Preventive Schedule, the completion of forms, and the preparations of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, except as required by law
- Methadone hydrochloride treatment (methadone maintenance) for which no additional functional progress is expected to occur

PRESCRIPTION DRUG COVERAGE

FORMULARY

Your plan uses a formulary, or list of Food and Drug Administration (FDA)-approved prescription drugs it covers. It covers products in every major treatment category. A committee of our pharmacists and physicians, called the Pharmacy & Therapeutics (P&T) Committee developed the formulary. This committee reviews and updates the formulary regularly.

To find out if a drug is on the formulary, please visit your plan's website at: **highmarkblueshield.com**

Select the **Find Doctors and Rx** tab. Next, choose the **Find a Drug** link. Then select your plan's formulary. Enter the name of the drug to begin your search. In-network providers can also view the formulary. Please refer to the website or talk with your health care provider for the most up-to-date information.

Your prescription drug program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed in the Summary of Benefits and Coverage.

PARTICIPATING RETAIL PHARMACIES

Your plan covers prescriptions when you purchase them through an in-network pharmacy. To find a participating pharmacy, go to your member website listed above. Select the **Find Doctors and Rx** tab. Then choose on **Find a Pharmacy**. Select the applicable pharmacy network as outlined in the Summary of Benefits and Coverage. Enter the location information and choose the **Locate Pharmacy** button.

MAIL ORDER PRESCRIPTIONS

For long-term or maintenance prescriptions, you can take advantage of our mail order pharmacy, Express Scripts®. To learn more or to get started, log in to your member website listed above. Select the **Prescriptions** tab and see the **Save With Mail Order** section. Find out how you can transfer a prescription or start a new one.

GENERIC DRUGS

Generic drugs have the same chemical composition and therapeutic effect as brand-name drugs and must meet the same Food and Drug Administration (FDA) requirements. Under your prescription coverage, you will pay the lowest copayment, or coinsurance amounts when you purchase generic drugs. You will pay a higher copayment for brand-name drugs. Depending on your coverage, if your provider authorizes a generic drug but you purchase a brand-name drug, you will be responsible for paying the cost difference between the brand-name drug and generic drug, as well as the brand-name drug copayment or coinsurance amounts.

SOME DRUGS NEED TO BE PRE-APPROVED (PRIOR AUTHORIZATION)

Some Highmark prescriptions require prior authorization, meaning our plan's approval is needed for coverage. You can check the formulary website or call Member Services to see which drugs are affected. Once prescribed, either your provider or you must request this authorization. Prior authorization decisions for covered drugs are typically made within 72 hours for urgent cases and 15 days for non-urgent cases. If a request is denied, both you and your doctor will receive a written explanation, including appeal instructions.

QUANTITY LIMITS

To help ensure the safe and effective use of prescription drugs, your Highmark plan includes quantity limits for some medications. This means the pharmacist will typically dispense only up to the recommended amount, even if your prescription is for more. In cases where a higher quantity is medically necessary, your doctor can contact Highmark to request an exception.

DRUGS NOT ON THE FORMULARY (EXCEPTIONS) — TIME FRAMES AND RESPONSIBILITIES

If you have a closed formulary, we must approve payment for drugs that are not on the formulary. If your doctor thinks you need to take a drug that is not on the formulary, your doctor will send us a request for approval. Decisions for drugs not on the formulary are typically made within 72 hours for urgent cases and 15 days for non-urgent cases. You or someone you designate can also request a non-formulary drug exception.

Exception requests can be mailed to the following address:

Clinical Pharmacy Services
P.O. Box 279
Pittsburgh, PA 15230

Exception requests may also be faxed to 1-866-240-8123 or emailed to RxMbrRequests@highmark.com.

Forms are available here: Rx Forms

If you are not happy with our decision on your request for a non-formulary drug, you can contact Member Service at the phone number on your member ID card and ask for an external review by an independent review organization. We will then send your request to another organization that will review your request and notify you of a decision within 72 hours for a standard request and 24 hours for an expedited request.

CLAIMS AND PAYMENTS

CLAIMS PAYMENT POLICIES AND PRACTICES

When you need medical care, you can choose between in-network and out-of-network providers. It's important to understand the difference because your choice affects how much you pay for services. For example, care from an out-of-network provider might not be covered except for emergencies or when the services are not available from an in-network provider.

Doctors and hospitals that participate with us are called "in-network" providers. In-network providers include primary care doctors, specialists, hospitals and a variety of treatment facilities. When you receive health care from an in-network provider, you typically pay less than you would at an out-of-network provider. If you have an HMO or EPO plan, you are not covered for out-of-network services (except for emergency services).

Doctors and hospitals that do not participate with us are called "out-of-network" providers. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get care.

HOW TO SUBMIT A CLAIM

A claim is a request you make for payment of the charges or costs for a covered service you received. If you receive services from an in-network provider, you do not have to file a claim. Your in-network provider takes care of that for you. If you go to an out-of-network provider, you may have to file the claim yourself. To file the claim yourself, simply follow these easy steps:

- Know your benefits. Review your Agreement to see if the services you received are eligible under your plan.
- Get a detailed bill that includes:
  - The name and address of the service provider
  - The patient's full name
  - Date of service
  - Description of the service/supply
  - Amount charged
  - Diagnosis or nature of illness
  - Doctor's certification for durable medical equipment
  - Nurse's license number and shift worked for private duty nursing
  - Total mileage for ambulance services
- Copy bills for your records. You must submit original bills. Once your claim is received, we cannot return the bills.
- Complete a claim form. Make sure all information is completed and dated properly.
- Attach all detailed bills to the claim form. Mail the form to the address on the form.

NOTE: Canceled checks, cash register receipts, or personal lists are not acceptable as bills.

Claim Forms may be obtained at: Medical_Claim_Form.pdf

You can also obtain a claim form by calling the Member Service number on the back of your member ID card. For questions, please call 1-800-345-3806.

You can submit your claim to:

Claims (plan code 363)
P.O. Box 890062
Camp Hill, PA 17089-0062

Claims (plan code 378)
P.O. Box 890173
Camp Hill, PA 17089-0173

A claim form is not required for member submitted claims. For alternative submission options, please contact member services.

You can file multiple services for the same family members with one claim form. However, you must complete a separate claim form for each covered member. You must submit your claim no later than 15 months after the date you received the services.

GRACE PERIOD

Your health plan includes a grace period for premium payments. For most plans, this is a 31-day period following the due date during which your coverage remains active, though claims may be temporarily held (pended). If full payment isn't received by the end of this grace period, your coverage will terminate. While coverage is active, you are still responsible for any cost-sharing amounts.

If you're enrolled in a Health Insurance Marketplace plan and receive advance premium tax credits (APTC), a 3-month grace period applies after at least one full monthly premium is paid. During the *first month* of this period, your plan will pay claims for covered services. However, during the *second and third months*, claims will be pended until you pay the outstanding premium in full. If you pay in full before the end of the 3-month period, all claims for covered services received during the entire grace period will be paid. If you do not pay the outstanding amount, your coverage will end, claims from months two and three will be denied, and you may be responsible for paying your provider directly for those services.

RETROACTIVE DENIALS

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim, we have already paid for you, you will become responsible for payment. Some reasons why you might have a retroactive denial include a claim that was paid during the second or third month of a grace period or a claim paid for a service for which you were not eligible. You can avoid retroactive denials by paying your premiums on time and in full and making sure you talk to your provider about whether the service being performed is a covered benefit. You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

EXPLANATION OF BENEFITS

Once your claim is processed, you may receive an Explanation of Benefits (EOB) from us. The EOB is not a bill. It's a statement that gives you information about the services you received. Services can be from physicians, facilities, or other professional providers. It also includes the costs you may owe for these services.

The EOB includes:

- The provider's charge
- The allowable amount
- The copayment, deductible, and coinsurance amounts, if applicable, that you're required to pay
- The total benefits payable
- The total amount you owe

To get your EOBs online, register on **highmarkblueshield.com**. Your EOB can also be mailed to you. If you do not owe payment to the provider, you may not receive an EOB.

For information on how to read and understand your EOB, please refer to **Explanation of Benefits FAQ | Highmark**

COORDINATION OF BENEFITS

If you have more than one health insurance plan, those plans need to work together to make sure you are getting the most out of your coverage. One plan is your primary plan. This plan pays your claims first. The other plan is your secondary plan and pays some of any costs remaining after your primary plan pays. If you have other health insurance coverage, you need to tell us so we can coordinate the benefits we provide with the other health insurance plan to establish payment of services. If you have any questions, you can call the Member Service number on the back of your Member ID card or 1-800-345-3806 or TTY 711.

OVERPAYMENT OF PREMIUM

If you believe you have paid too much for your premium and should receive a refund, please call the Member Service number on the back of your ID card.

HOW WE PROTECT YOUR RIGHT TO PRIVACY

At Highmark, we have established policies and procedures to protect the privacy of our members' protected health information (PHI) from unauthorized or improper use. We restrict access to our members' non-public personal information to only individuals who need to know that information to provide you with health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to safeguard against unauthorized access, use and disclosures. PHI may be oral, written, or electronic.

For example, as permitted by law, we may use or disclose PHI for treatment, payment, and health care operations. This could include claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review, and underwriting. With the use of measurement data, we are able to help manage our members' health care needs. We can identify certain individuals who could benefit from health, wellness, and condition management programs.

If we ever use your PHI for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas. You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes not discussing PHI outside of our offices, confirming who you are before we discuss PHI on the phone, requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your PHI, and including confidentiality language in our contracts with doctors, hospitals, vendors, and other health care providers.

For more information about our privacy practices, please review our Notice of Privacy Practices at: HIGHMARK INC. NOTICE OF PRIVACY PRACTICES RCD-028

We provide aggregate information to employer groups whenever possible. In those instances when PHI is required, the employer group will be required to sign an agreement before the information is released.

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